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★ NOV 15 2019 ★

CASE # 19 CV 5472 (JMA)(AYS)

LONG ISLAND

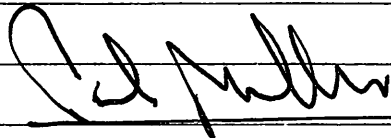
DEAR JUDGE SHIELDS:

DATE 11-15-19

IN RESPONSE TO
ORDER DATED OCT 24TH 2019 I AM
REQUESTING AN EXTENSION OF TIME OF
APPROXIMATELY SIX MONTH OR TILL I'M OUT
OF REHAB FACILITY
CURRENTLY I'M IN COLD SPRING HILL CENTER
AND ATTACHING LETTER OF MY DAY OUT TO
COME HERE INSTEAD TO BE BACK THERE I
WAS ABLE TO COME OUT FOR TODAY ONLY
ONCE I AM OUT I PLAN TO SEE PRO SE
CLINIC AS I DON'T HAVE FUNDS TO HIRE ATTORNEY

Sincerely Thankful

PAUL MULLER JR



RECEIVED

NOV 15 2019

EDNY PRO SE OFFICE

cc PLAINTIFF

MY ADDRESS

106 STEAMBOAT RD

GREAT NECK NY 11024



378 Syosset-Woodbury Road . Woodbury, NY 11797

RESIDENT: Walter Reed
ROOM: 10

OUT ON PASS SUMMARY

This form is to be completed and signed only after a Physician's Order has been written.

☐ Day Pass☐ Escorted☐ Unescorted☐ Therapeutic Leave (Overnight)☐ Escorted☐ Unescorted**Escorted Pass or Therapeutic Leave**Responsible Party: ☐ Walter Reed Relationship: Walter ReedAddress: Walter ReedDestination address: Walter Reed Telephone #: Walter ReedDate and time of departure: 11-15-19 11:00 AMDate and time of anticipated return: 11-15-19 11:00 AM**Unescorted Pass or Therapeutic Leave**Responsible Party: ☐ Resident: _____ Relationship: Self

Address: _____

Destination address: _____ Telephone #: _____

Date and time of departure: _____

Date and time of anticipated return: _____

I understand the terms of this pass agreement and that if I do not comply, future out on pass requests may be denied.

If you require any assistance while you are out on pass or therapeutic leave, please contact Cold Spring Hills Center for Nursing & Rehab at **(516) 921-3900** and ask for the Nursing Supervisor.

In the event of a medical emergency, call "911".

I release Cold Spring Hills Center of Nursing & Rehabilitation, its directors, officers, personnel and agents, and my attending and treating physician(s), from any and all liability for any and all consequences including any accident mishap or deterioration of condition, while off premises.

I have received the following: ☐ medication ☐ equipment ☐ patient/caregiver education

☐ Resident has Cold Spring Hills ID bracelet in place. ☐ Resident has copy of non hospital DNR if appropriate.

By signing this form, I acknowledge that if I do not return to Cold Spring Hills Center for Nursing and Rehabilitation by the expected date and time of my return, this document can become a signed "Leaving Against Medical Advice" form and may forfeit my residential rights at Cold Spring Hills Center for Nursing and Rehabilitation

Responsible Party/ Date

Licensed Nurse/Date

Distribution: Original-Chart, Pink-Responsible Party/Resident, Yellow- Receptionist/Security at Front Desk